SUPERVISOR'S ACCIDENT REPORT
WORKERS' COMPENSATION CLAIMS

York Insurance Services Group, Inc
PO Box 619079
Roseville, CA 95661
(916) 783-0100
FAX (916) 783-0335

DATE & TIME REPORTED:

OSHA CASE NO:

COMPANY	LOCATION	LOCATION CODE NO:
Scotts Valley Fire Protection District	*7 Erba Lane, Scotts Valley, CA, 95066*	*1100*

A. EMPLOYEE

NAME		JOB TITLE
DEPARTMENT *Scotts Valley Fire Protection District 1100*	☐ LOST TIME ☐ NO LOST TIME	☐ FIRST AID

B. TIME AND PLACE OF ACCIDENT

DATE	HOUR	DEPARTMENT	IMMEDIATE SUPERVISOR
		1100	

IDENTIFY EXACT LOCATION WHERE ACCIDENT OCCURRED *(Be specific)*

JOB OR ACTIVITY AT TIME OF ACCIDENT *(Be specific)*

C. WITNESSES - *List of Names and Addresses*

Name	Address

D. DESCRIBE THE ACCIDENT/ACCIDENT CAUSE - *Please be specific*

E. UNSAFE ACT/CORRECTIVE ACTION TAKEN - *Include both employee and supervisor corrective actions to prevent future occurrences.*

EMERGENCY - WENT TO THE DOCTOR

☐ YES

☐ NO

If yes, please fill out the following information:

Name of Doctor: ______________________________

Address of Doctor: ______________________________

☐ NON-EMERGENCY, BUT PLAN ON SEEING A PHYSICIAN
Physician's Name: ______________________________

☐ NO MEDICAL ATTENTION NEEDED